MARIAN DAVIS DPM PA

Marian Footcare

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New Patient Consultation

Use this form during a new patient visit to collect personal information and medical history.

Patient name: _____ Age: _____

Ht _____ Wt_____ Shoe size_____

Vitals: BP _____ Pulse _____ Resp _____ Temp _____

MD _____

How did you hear about us?
Family/friend/patient/newspaper/YellowPages/radio/tv/insurance company/ employer/other_____

Medications:_____
_____

Family history: mother/father/brother/sister: diabetes/heart disease/cancer/high bp/other_____
_____

Foot problem(s):
_____
_____

Where: _____ How long? ____days/wks/mos/yrs

Pain scale (1-10) _____ Describe pain _____
_____

Cause of foot problem: injury/deformity/unknown/ other _____

Aggravated by: walking/standing/shoes/physical activity

Treatment provided in the past: PCP/foot doctor/chiropractor/orthopedic surgeon/physical therapist/ER doctor

Treatment: X-rays/taping padding/medication/injections/orthotics/wound care/ foot surgery

Type of foot surgery _____
_____

Foot doctors seen in the past and when:
_____
_____

Have you ever had (circle all that apply): bunions/hammertoes/heel spurs/corns/ calluses/ingrown toenails/fungus toenails/athlete's foot/warts/flat feet/high arches/pinched nerves

Do you regularly take: blood thinners? (aspirin, Coumadin, vitamin E)
Cortisone or other steroids? _____

Past/current medical history (circle all that apply):

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Diabetes (controlled by: insulin/pills/diet)
High BP/stroke
Heart attack/leaky valve
Irregular heartbeat/congestive heart failure
High cholesterol
Cancer (type) _____
Epilepsy
Osteoarthritis/rheumatoid arthritis
Degenerative joint disease/gout
Poor circulation/varicose veins
Cirrhosis/hepatitis
Asthma/bronchitis/COPD
Stomach/bowel problems

Bladder/kidney/urinary trouble
Parkinson's/Alzheimer's
Headaches/depression/anxiety
Skin trouble/rashes
Leg/foot sores/ulcers
Dentures/glasses
Thyroid trouble
Joint replacement
Bleeding problems/anemia
Blood clots
Slow wound healing
Hayfever/allergies
Surgical complications

Medication/substance allergies (circle all that apply):

Latex/tape/ iodine/ivp dye/shellfish

Have you ever taken a medication that caused a skin rash, facial swelling, or difficulty breathing? Y / N If yes, please list medication name and reaction:
_____
_____

Have you ever taken a medication that caused vomiting, nausea, dizziness, diarrhea, or headache? Y / N If yes, please list medication name and reaction:
_____
_____

Have you ever had trouble with spinal, general, or local anesthesia? Y / N If yes, please explain: _____
_____
_____

Social history
Single / married / widowed / divorced Occupation_____
Current smoker? If so, how many packs/cigs per day? _____
How long have you been smoking? _____
If former smoker, quite date: _____
Alcohol: How many drinks per day/week/month? _____
Surgeries / hospitalizations / childbirth history (list dates/procedures):
_____
_____
_____